

**HEALTHY INDIANA PLAN DEMONSTRATION**

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**ANNUAL REPORT**

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**HEALTHY INDIANA PLAN**<sup>SM</sup>  
Health Coverage = Peace of Mind



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## Executive Summary

As stated in the initial Waiver Proposal, The Healthy Indiana Plan (HIP), which passed the Indiana General Assembly in 2007 with bipartisan support, builds upon the State's long history with consumer-driven health plans. Indiana pioneered the concept of medical savings accounts in the commercial market and is the first and only state to apply the consumer-driven model to a Medicaid population. Provided by private health insurance carriers, HIP offers its members a High Deductible Health Plan (HDHP) paired with the Personal Wellness and Responsibility (POWER) account, which operates similarly to a Health Savings Account (HSA).

The private health insurance experience provides an alternative to traditional Medicaid and promotes consumerism by requiring members to make contributions into their accounts. The contributions are designed to preserve dignity among members receiving public assistance and provide them with "skin in the game," which empowers them to demand price and quality transparency as they make cost-conscious health care decisions and take responsibility for improving their health. In addition, the infusion of market principles works to educate members and prepare them to participate in the private market when they are able to transition off the program.

Since 2008, HIP has demonstrated remarkable success in promoting healthy lifestyles and appropriate utilization of health care services by increasing preventive care and decreasing inappropriate use of hospital emergency departments. The program has achieved notable improvements in health care utilization patterns as compared to a traditional Medicaid model that provides little incentive for participants to consider the cost of their publicly funded care or to take personal responsibility for their health.

HIP members have consistently sought primary and preventive care at higher rates than traditional Medicaid members and have utilized hospital emergency departments for non-urgent care less often than their Medicaid counterparts.<sup>1</sup> Mathematica's 2013 survey of current HIP members showed that that an overwhelming majority of members - approximately ninety-five percent (95%) - are satisfied with the program, and ninety-eight percent (98%) indicated they would re-enroll if they left the program but became eligible again.<sup>2</sup>

After six years of demonstrated success, the State of Indiana replaced its traditional Medicaid program for all non-disabled adults ages 19-64 and expanded HIP to those who fall below 138% of the federal poverty level (FPL). The series of design elements implemented in the new Section 1115 Demonstration waiver (HIP 2.0) further HIP's core objectives: make Hoosiers healthier, provide new coverage pathways for uninsured Hoosiers, promote employer sponsored health insurance, create incentives for Hoosiers to transition from public assistance to stable employment, promote personal responsibility, and engage participants in making health care decisions based on cost and quality.

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<sup>1</sup> Healthy Indiana Plan Section 1115 Demonstration Project Number: 11-W-00237/5 2013 Annual Report and Interim Evaluation Report. Submitted by the Indiana Office of Medicaid Policy and Planning, October 2014.

<sup>2</sup> Healthy Indiana Plan Section 1115 Demonstration Project Number: 11-W-00237/5 2013 Annual Report and Interim Evaluation Report. Submitted by the Indiana Office of Medicaid Policy and Planning, October 2014.

HIP 2.0 augmented the existing waiver by offering HIP to individuals previously excluded from the program due to eligibility restrictions and the enrollment caps designed to maintain budget neutrality. This expansion targets an estimated 559,000 uninsured non-disabled adults ages 19-64 under 138 percent of the FPL, but assumes that the take-up rate will be lower initially as the program ramps-up.<sup>3</sup> Further, HIP 2.0 maintained and strengthened the POWER account by increasing the dollar value, consistent with current health savings accounts (HSA) standards, to incentivize all HIP members to be prudent utilizers of health care, manage their account appropriately, and seek preventive care. This increased dollar value also serves to more closely align the POWER account with consumer-driven options available in the commercial market. HIP 2.0 simultaneously lowered required contributions for all members to ensure POWER account affordability.

Consistent with the State's original enabling legislation, HIP 2.0 promotes private employer based coverage over public assistance by implementing a new optional defined contribution premium assistance program, HIP Employer Benefit Link (HIP Link), designed to support individuals wishing to purchase their employer's sponsored health insurance.

Under HIP 2.0, members who consistently make required contributions to their POWER account will maintain access to the "HIP Plus" plan that includes enhanced benefits such as dental and vision coverage. Members under 100 percent of the FPL who do not to make monthly POWER account contributions will be placed in the "HIP Basic" plan, a more limited benefit plan. The HIP Basic plan maintains essential benefits, but incorporates reduced benefit coverage and a more limited pharmacy benefit. The HIP Basic plan, unlike HIP Plus, will also require co-payments for all services. In sum, HIP 2.0 provides a significant value proposition that incentivizes members to make POWER account contributions.

Recognizing the strong tie between work and health, HIP 2.0 further promotes private market coverage and employment by introducing the HIP's Gateway to Work program. This program requires that HIP participants be referred to the State's workforce training programs and work search resources to create opportunities for HIP members to connect with potential employers. The State aims to assist and encourage HIP members to secure and retain meaningful employment, which will not only improve health outcomes, but will help these individuals become more self-sufficient, and ultimately, complete their transition off public assistance.

HIP 2.0 enhances Indiana's long tradition of leadership in consumer-driven health care; further, it fully preserves the program's approach of combining personal responsibility and consumerism with incentives for positive health behaviors. The enhancements in HIP 2.0 build upon successes in the original HIP program by ensuring access to quality health coverage for low-income Hoosiers while simultaneously creating a pathway for members to achieve independence from public assistance.

## **A. Program Accomplishments**

Since its inception in February of 2015, the HIP 2.0 program has seen accomplishments in an array of areas. Key accomplishments in a range of categories are summarized below.

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<sup>3</sup> Milliman. June 23, 2014. "1115 Waiver – Healthy Indiana Plan Expansion Proposal: Healthy Indiana Plan Budget Neutrality Projections."

## ***Enrollment***

- There are approximately 370,000 Indiana residents enrolled at the end of the first year. This included fully enrolled (approximately 340,000) and conditionally enrolled (approximately 30,000) individuals.<sup>4</sup>

## ***Affordability***

- Since HIP began, almost 70 percent of members ever-enrolled in HIP 2.0 during the first demonstration year have elected to make contributions to their POWER account.
- Over 80 percent of members in HIP Plus, which requires POWER account contributions, are earning below the poverty level.
- HIP participants are making these contributions themselves; data show that less than one percent have been aided by not-for-profit organizations, employers, or providers.
- Of the members who started making contributions and earn less than the poverty level, approximately 93 percent continue to make them.
- Of the members who are in HIP Plus and earn above the poverty level, about 94 percent make their required contributions.

## ***Consumer Directed Healthcare***

- About one-third of members report asking their doctors about the cost of their health care.<sup>5</sup>
- Of members reporting that they have a POWER account, more than half check the balance of their POWER account and approximately 40 percent check their balance at least once a month.<sup>6</sup>

## ***Gateway to Work***

- Over 3,200 HIP members have used job search and training programs through the Gateway to Work Program. Indiana will continue efforts to increase employment, self-sufficiency, and independence.

## ***Satisfaction***

- Over 80 percent of HIP Plus members answered either that they were satisfied or very satisfied with the program.<sup>7</sup>
- Over 90 percent of all HIP members would re-enroll and about 80 percent would pay more to be in the program.<sup>8</sup>

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<sup>4</sup> Conditionally enrolled members include those that are in Presumptive Eligibility status, as well as those that are deemed eligible but are in the 60-day window to make their first PAC.

<sup>5</sup> Lewin analysis of 2015 HIP 2.0 Member survey.

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

### ***Provider Data***

- 55% of providers surveyed indicate they have seen a decline in the number of people without insurance and almost 40 percent have seen a decline in the requests for charity care. 72% of providers indicate that HIP will improve health care in Indiana.
- Since HIP 2.0 began, over 5,300 new providers have signed up to serve both the Medicaid and HIP populations.

### ***Emergency room***

- The participating managed care organizations report that emergency room utilization is lower by an average of 42 percent for individuals that moved from Medicaid into HIP. Enrollees are learning to seek primary and preventative care rather than going to the ER so that total health care needs are addressed and managed more effectively.
- The percentage of ER claims that are deemed non-emergent has decreased steadily during the first three quarters of the first demonstration year. The percentage for Plus members was lower compared to Basic members throughout the first three quarters, but decreased from 14.2 percent in the first quarter to 12.7 percent in the third quarter. The decrease was more substantial for Basic members (30.1 percent to 12.0 percent). These decreases may be indicative of the maturation of the program as members become increasingly accustomed to their new coverage benefits and incentives. In addition, this may also indicate that HIP Plus members making contributions utilize the system in different ways than HIP Basic members that are not making contribution.

### ***HIP Link***

- There are currently 31 employers (including small, medium, and large businesses) participating in HIP Link.

## Goal of Report

The goal of this report - *Indiana HIP 2.0: Annual Report for Demonstration Year One* - is to provide a progress report for the HIP 2.0 activities conducted from February 1, 2015 through January 31, 2016, as required by the Centers for Medicare & Medicaid Services (CMS). This report focuses on operational, enrollment, and fiscal accomplishments for the first program year and summarizes the four Quarterly Reports provided to CMS in the first Demonstration Year.

CMS approved Indiana's 1115 waiver, "HIP 2.0," which took effect on February 1, 2015. The Special Terms and Conditions (STCs) for Indiana's 1115 Demonstration require that Indiana provide an Annual Report for each Demonstration Year and conduct an Interim and Final Evaluation for the demonstration. Through a competitive procurement process, the Lewin Group was hired by the State of Indiana to conduct the HIP 2.0 evaluation, including the forthcoming Interim Evaluation Report. The Interim Evaluation Report will be submitted to CMS on June 30, 2016.

## Program History

Traditional Medicaid programs offer coverage to vulnerable individuals, but numerous studies indicate poor health outcomes in spite of high spending. A University of Virginia study found that Medicaid patients are almost twice as likely to die after an inpatient surgery, stay in the hospital 42 percent longer, and cost 26 percent more than individuals with private health insurance.<sup>9</sup> A study conducted by Johns Hopkins similarly found higher mortality rates among Medicaid patients, indicating they are 29 percent more likely to die within three years following receipt of a lung transplant.<sup>10</sup> Additionally, the Oregon Health Insurance Experiment found that providing Medicaid coverage to previously uninsured residents resulted in lackluster impacts on health outcomes – this includes a failure to show improvements in many important health outcome domains such as measured blood-pressure, cholesterol, and glycated hemoglobin levels.<sup>11</sup>

The HIP model was developed as an alternative to traditional Medicaid in order to harness the success of the private health insurance market to lower costs and improve health outcomes for Medicaid enrollees in the state. The program utilizes an account similar to an HSA that empowers enrollees to become active consumers of health care services and to evaluate cost and quality of services.

HIP's consumer-driven design creates incentives for members to exercise personal responsibility and live healthy lifestyles. This design encourages members to take control of their health care spending and to be active purchasers of health care services. While other cost control measures target providers and insurers, HIP brings the member directly into the equation, aligning incentives across all parties and uniquely empowering the individual to demand cost and quality transparency. Through the introduction of these market forces, HIP has seen greater cost containment compared to traditional Medicaid.<sup>12</sup>

### A. Historical Context

Indiana has a long and rich history with consumer-driven health care programs. In 1992, Indiana based Golden Rule Insurance Company executive, J. Patrick Rooney, pioneered the concept of medical savings accounts with his own employees. Based on its success encouraging his employees to make more cost-conscious health care decisions, Rooney began selling medical savings account plans in 1996 and played an integral role in securing Congressional authorization for tax advantaged Health Savings Accounts (HSAs) in 2003.

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<sup>9</sup> Avik, Roy. (2012). The Medicaid Mess: How Obamacare Makes It Worse. Retrieved from: [http://www.manhattan-institute.org/html/ir\\_8.htm](http://www.manhattan-institute.org/html/ir_8.htm). LaPar DJ et al., Primary payer status affects mortality for major surgical operations. *Annals of Surgery*. 2010 Sep; 252(3): 544–51.

<sup>10</sup> Avik, Roy. (2012). The Medicaid Mess: How Obamacare Makes It Worse. Retrieved from: [http://www.manhattan-institute.org/html/ir\\_8.htm](http://www.manhattan-institute.org/html/ir_8.htm). Allen JG et al., Insurance status is an independent predictor of long-term survival after lung transplantation in the United States. *Journal of Heart and Lung Transplantation*. 2011 Jan; 30(1): 45–53.

<sup>11</sup> Baicker, K., et al.. (2013). The Oregon experiment – effects of Medicaid on clinical outcomes. *New England Journal of Medicine*, 368(18), 1713-1722..

<sup>12</sup> The ability of the HIP program to achieve financial and budget neutrality is described in: Healthy Indiana Plan Section 1115 Demonstration Project Number: 11-W-00237/5 2013 Annual Report and Interim Evaluation Report. Submitted by the Indiana Office of Medicaid Policy and Planning, October 2014.

In 2006, the State of Indiana introduced consumer-driven health plan options to its nearly 30,000 employees and their dependents. By 2010, 85 percent of state employees elected to enroll in a High Deductible Health Plan (HDHP) option attached to an HSA. In 2013, 96 percent of state employees chose a consumer-driven health plan option.

The number of consumer-driven plans in the Indiana commercial health insurance market has also continued to increase. As of January 2014, 396,934 Indiana residents had HDHPs/HSAs representing about eleven percent of the commercial market enrollment (greater than the U.S. average of ten percent). Among all states, Indiana ranked eleventh in the percentage of HDHP/HSA enrollees under age 65 with private health insurance.<sup>13</sup>

The impact of the consumer-driven model on health care consumption and spending is significant. Research demonstrates that the HDHP/HSA model in the private market significantly changes member utilization patterns. The State of Indiana saved an average of 10.7 percent in health care costs annually in its first four years offering HDHPs with HSAs to state employees.<sup>14</sup> The State found that employees enrolled in the HDHP/HSA option used hospital emergency departments at lower rates than those in the traditional plan and had fewer physician office visits, lower prescription costs, and a higher generic medication dispensing rate.<sup>15</sup>

General studies have shown that HSAs are effective in helping consumers make value-based healthcare decisions that ultimately lower costs and increase quality. A five-year Employee Benefit Research Institute study examined health care spending trends after a large Midwest employer replaced its traditional insurance plans with paired HDHPs and HSAs. The study found that total health care spending decreased by 25 percent in all categories in the first year. Additional declines in the pharmacy and laboratory spending categories were observed in subsequent years.<sup>16</sup>

Insurance companies report lower hospital emergency department and specialist use by those with HSA-linked plans.<sup>17</sup> In 2011, an Employer and Account Holder survey found that fifty-four percent (54%) of HSA account holders reported having set aside more money than ever before to pay for health care costs, and twenty-eight percent (28%) reported the account encouraged them to shop for lower-cost prescription drugs.<sup>18</sup>

Given Indiana's rich history and proven record of accomplishment with consumer-driven health care, the State used these principles to develop a plan to address its uninsured residents and their health needs. Prior to HIP, the Indiana Medicaid program had one of the lowest eligibility thresholds in the nation. There was little support to expand the State's traditional Medicaid program. There was also a concern that a traditional Medicaid program would be

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<sup>13</sup> America's Health Insurance Plans, Center for Policy and Research. (July 2014) January 2014 Census Shows 17.4 Million People Covered by Health Savings Account/High-Deductible Health Plans (HSA/HDHPs).

<sup>14</sup> Gusland, C., Harshey, T., Schram, N., & Swim, T. (2010). Consumer-driven health plan effectiveness, case study: Indiana. Mercer Health & Benefits, LLC.

<sup>15</sup> Ibid.

<sup>16</sup> Fronstin, P. & Roebuck, C.M. (2013). Healthcare spending after adopting a full replacement, high deductible health plan with a Health Savings Account: A five year study. Employee Benefit Research Institute.

<sup>17</sup> Sammer, J. & Miller, S. (2011). Consumer-driven decision: weighing HSAs vs. HRA's.

<sup>18</sup> Miller, S. (2011). HSAs viewed as cost-saving options by employers and account holders.

unlikely to significantly improve participant health status given its lack of incentives for appropriate healthcare utilization.

Following input from numerous stakeholder meetings and bipartisan collaboration, the State of Indiana, under the leadership of Governor Mitch Daniels, designed the Healthy Indiana Plan (HIP) to introduce healthcare consumerism and private market principles to the Medicaid program. The program was initially designed to maintain limited enrollment in order to ensure a balanced State budget, and was funded through an increased cigarette tax. During the 2007 legislative session, Rep. Charlie Brown authored and Sen. Patricia Miller sponsored a bipartisan bill enabling HIP. With broad bipartisan approval, the Indiana Family and Social Services Administration (FSSA) developed an implementation plan and obtained a federal waiver approval from CMS. On January 1, 2008, HIP began enrolling working-age, uninsured adults in coverage.

In 2011, following the passage of the Patient Protection and Affordable Care Act (ACA), the Indiana General Assembly reinforced its support for HIP by calling for HIP to be the coverage vehicle for a Medicaid expansion. The legislature passed Senate Enrolled Act 461 (codified at Indiana Code §12-15-44.2), which made several conforming changes related to the ACA, including revising program eligibility thresholds to align with the Marketplace coverage options available to individuals beginning in 2014. In addition, the legislation included a provision authorizing the Secretary of the Family and Social Services Administration to “amend [HIP] in a manner that would allow Indiana to use the plan to cover individuals eligible for Medicaid resulting from the passage of the [ACA].”

The State has repeatedly sought approval to expand and extend HIP coverage. In September 2012, CMS granted a one-year extension, and subsequently provided one-year extensions again in 2013 and 2014.

Under the leadership of Governor Mike Pence, the State developed the Healthy Indiana Plan (HIP) 2.0 proposal, which CMS approved in January 2015. HIP 2.0 maintained the principles of the original program but added new choices for participants. In particular, the landmark waiver introduced HIP Basic, HIP Plus and HIP Link. With the advent of Basic and Plus, individuals below 100 percent of FPL are no longer locked out if they fail to make their POWER account contribution, rather they move from HIP Plus to HIP Basic. Further, HIP 2.0 also decreased the lock-out period (for individuals over 100 percent of FPL) from 12 months under HIP 1.0 to six months. HIP Link offered a defined contribution premium assistance program and the Gateway to Work program to encourage work. Together, these changes to the original HIP program strengthen consumer driven health care while providing incentives for individuals to take ownership for their health. Specifically, the waiver goals are:

1. Reduce the number of uninsured low-income Indiana residents and increase access to health care services
2. Promote value-based decision-making and personal health responsibility
3. Promote disease prevention and health promotion to achieve better health outcomes
4. Promote private market coverage and family coverage options to reduce network and provider fragmentation within families

5. Provide HIP members with opportunities to seek job training and stable employment to reduce dependence on public assistance
6. Assure State fiscal responsibility and efficient management of the program

## Overview of Annual Report

This report summarizes the Quarterly Reports, which illustrate the program's focus in the last year. This includes data on operational efforts, as well as statistics on enrollment, POWER account contributions, closures, eligibility processing, presumptive eligibility and expenditures.

## Summary of Demonstration Year One Activities

This section provides a summary of operational and administrative updates for the HIP 2.0 program, since its launch in February 2015.

### A. Initial Implementation

While negotiating the waiver, the State initiated a simultaneous parallel effort to implement the program. These efforts focused on coordinating a multi-department, multi-vendor team, who collaborated to prepare the eligibility, Medicaid Management Information System (MMIS) and the managed care systems to expand eligibility and operate the new program design. In addition, the State amended Medicaid managed care contracts to reflect new program requirements under HIP 2.0, developed stakeholder training materials, as well as member communication materials including member notices. An immediate legislative action, the emergency rule, was put into place on February 1, 2015 which temporarily added provisions affecting applicants, members, and providers concerning eligibility, enrollment, benefits, and policy for HIP 2.0. This approach enabled the State of Indiana to begin taking applications for HIP 2.0 on January 27, 2015, and to begin providing services under the new program on February 1, 2015.

During the first year of implementation, the State dedicated resources focused on the customer experience and operations. Several weekly meetings occurred with the Managed Care Entities (MCE) and enrollment brokers, to identify and address member, system and operational issues. In addition, a specialized unit – the Customer Service Team – handled unique member issues and identified any possible systemic issues as quickly as possible.

### B. Managed Care Readiness and Network Accessibility

Indiana HIP program managers collaborated closely with MCEs through the initial year of the program. From the beginning, the MCEs were included in the State's HIP 2.0 design sessions, in order to facilitate the implementation. This readiness review also focused on the adequacy of provider networks, including dental, vision, and pharmacy providers – which were new benefits added under HIP 2.0.

Indiana conducted readiness reviews to ensure quality operations. Throughout this process, the State monitored and evaluated the MCEs' ability to provide adequate access to care and quality health care. Readiness reviews included both desk reviews and several on-site reviews for each plan. A team of experts from the State provided standard language on various HIP 2.0 written materials including, but not limited to: (i) member information, (ii) provider credentialing information, (iii) public promotional material, and (iv) MCE policy and procedure documentation.

All three MCEs have been proactive in their network development to assure that there are adequate provider networks in place for all services, including the new dental and vision benefit and pharmacy carve-in.

### **C. Coordination with Pharmacy Benefit Manager and Dental Benefit Manager**

The State oversaw the return to the carve-in of pharmacy services in HIP Link. They were established on the State website for providers to access formulary information for all HIP-based plans. The State also put in place provisions so that the existing fee-for-service pharmacy vendor could process prescriptions for transitioning members for the first 30 days to minimize interruptions in coverage.

All three MCEs opted to work with a dental benefit manager to implement the new HIP Plus dental benefit. The State developed several dental-specific provider bulletins to help providers understand the design of the HIP 2.0 dental benefit.

### **D. Consumer Outreach to Potentially Eligible Households and Education on Benefits**

Member outreach and education was a key area of focus with the launch of the program. Initially, the State attempted to notify individuals enrolled in Marketplace qualified health plans (QHPs) with income between 100 percent and 138 percent of the FPL about the availability of coverage through the expanded HIP program. However, the data from the federal government on QHP enrollees was limited. In addition, the federal Marketplace policy did not require individuals above 100 percent of the FPL that were enrolled in the Marketplace to move to HIP. Furthermore, the Marketplace did not issue any communications to enrollees explaining their new option. New enrollees that applied to the Marketplace were referred to HIP if eligible, but existing enrollees were not. This may have impacted enrollment in HIP above 100 percent of the FPL, although there were nearly 50,000 such members enrolled as of the end of the first year. According to federal government reports, there were 67,875 Health Insurance Marketplace enrollees with less than 150 percent of the FPL in 2015, with the vast majority – 64,216 – between 100 percent and 150 percent.<sup>19</sup> The 2015 open enrollment period ended just as HIP 2.0 started, so these enrollees did not receive information through the Marketplace about HIP 2.0. In 2016, enrollment for Indiana residents with income between 100 percent and 150 percent of the FPL decreased to about 41,000.<sup>20</sup>

An ongoing priority of the State for HIP 2.0 is encouraging members to make HIP Plus contributions, as data indicate that individuals making contributions to their POWER account utilize the health system in more appropriate ways and are more engaged in their health.<sup>21</sup> Managed care plans did outreach to educate members and providers about the advantages of HIP Plus. In addition, the managed care plans engaged in active outreach to new members to explain and set up an appropriate payment mechanism. These efforts were largely successful, with an average of 70 percent of HIP members making contributions.

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<sup>19</sup> Office of the Assistant Secretary for Planning and Evaluation, July, 1 2015 “2015 Plan Selections by County in the Health Insurance Marketplace.” Available as of April 27, 2016 at: <https://aspe.hhs.gov/basic-report/2015-plan-selections-county-health-insurance-marketplace>.

<sup>20</sup> Office of the Assistant Secretary for Planning and Evaluation, March, 11 2016 “Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report; State level Data Excel tables.” Available as of April 16, 2016 at: <https://aspe.hhs.gov/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report>. According to the report, for enrollees with income data available, about 21 percent were between 100 percent and 150 percent of the FPL and there were a total of 196,242 enrollees.

<sup>21</sup> Healthy Indiana Plan Section 1115 Demonstration Project Number: 11-W-00237/5 2013 Annual Report and Interim Evaluation Report. Submitted by the Indiana Office of Medicaid Policy and Planning, October 2014.

An additional challenge included the collective engagement of the hundreds of intercessory stakeholders across Indiana, including hospitals, healthcare systems, insurance brokers and healthcare navigators who owned relationships with uninsured Hoosiers. Once the waiver was approved, the campaign to bring healthcare coverage to eligible uninsured Hoosiers throughout Indiana was initiated.

To maximize public-relation initiatives and efforts, both member and other stakeholder research were used to inform the strategic outreach plan, development of tactics and communication channels.

- Member research – In the early spring of 2015, advertising and outreach concepts were tested with 29 HIP 2.0 members and potential applicants via focus groups conducted among individuals in both highly populated urban areas as well as a low-income, high-uninsured rural area of Indiana. Qualitative data were collected to test a range of awareness elements. All groups unanimously selected the same campaign concept from three options, and it was used as the driver for all HIP 2.0 message framing and material design.
- Other stakeholder research – FSSA engaged stakeholders in in-depth interviews, informal surveys and feedback sessions to create reports and documents that were also later used in the 2015 campaign launch. One crucial finding was that while healthcare systems, providers, insurance brokers and healthcare navigators pledged their support, they requested a “communication kit” to help disseminate branded materials and information to participate. Stakeholders, including minority organizations, also provided specific information on how to effectively communicate with potential HIP 2.0 applicants.

The approach to HIP 2.0 outreach was to raise broad awareness and interest via promotion, driving potential enrollees to the stakeholders to assist with the enrollment process. The campaign supported the stakeholders by providing promotional materials and officials for events and presentations, and helping them leverage their own existing communication networks, channels and community partnerships to engage potential enrollees in their areas. A master plan was created and divided into strategies uniquely relevant to each identified stakeholder group, complete with respective measurable objectives, customized campaign messages, tactics and evaluation metrics/methods. The goal was to form an army of public ambassadors consisting of enrollment organizations, MCEs, provider groups, etc., to support enrollment efforts. These public ambassadors submitted action plans prior to the launch of the program, which outlined public relation strategies for the future.

As discussed above, member research informed the HIP 2.0 message framing with the theme of “With it, Without it,” which is intended to show the hardship that occurs when Hoosiers don’t have healthcare coverage, and the peace and improved healthcare that can result when Hoosiers do have it. The campaign theme was used across all channels – broadcast, print, outdoor and transit, and digital advertising, Web banners, social-media posts, media outlets, etc. The following major tactics were instrumental in the enrollment success:

- **Communication kit** – a turnkey, online kit that contained a range of HIP 2.0 branded materials. This fulfilled the need for materials that stakeholders had indicated in the secondary research.

- **Media outreach** – media events, news releases, reporter sit downs, letters to the editor and op-eds were all used to leverage media coverage for stakeholders across the state.
- **Events and presentations** – at stakeholder requests, FSSA leaders spanned the state giving presentations in local communities to help educate Hoosiers and stakeholders about the HIP 2.0 program.
- **Online training** – online training modules were developed to educate stakeholders on HIP 2.0. Questions about the program were embedded into the State’s healthcare navigator training.
- **Advertising** – print, broadcast (radio/TV), outdoor and transit, and social-media/digital advertising ran in communities across the state from June 2015 – December 2015. Additionally, should people see an advertisement and want immediate information, they were encouraged to text a hotline number for additional information.<sup>22</sup>
- **Web communication** – the HIP 2.0 website<sup>23</sup> served as the central landing site for information about the program; all materials and promotions drove traffic to the site and the program telephone number.
- **Brochures (English/Spanish)** – Brochures were made available in English or Spanish for order via the online communication kit.

Additionally, outreach coordinators cross referenced HIP 2.0 enrollee lists with the Supplemental Nutrition Assistance Program (SNAP) to see if there were households enrolled in SNAP that were not enrolled in HIP, as there are overlapping eligibility criteria. If households were not enrolled in HIP, they were sent a direct mailer with program information.

With regard to enrollment, actuarial projections estimated that approximately 320,000 Hoosiers would enroll in the HIP 2.0 program at the end of the first demonstration year.<sup>24</sup> By the end of the year, approximately 370,000 Indiana residents were fully or conditionally enrolled. In the “Detailed Annual Enrollment” section, detailed information is displayed on how the membership is distributed across counties, by race, age and Aid Category. From those exhibits, it is clear that there is robust membership across all parts of the state. Helping drive that success, more than 500 communication kits were downloaded, and FSSA staff participated in more than 80 presentations across the state to stakeholder organizations and community residents. Additionally, more than 150 media placements were achieved, along with 522,283 visits to the HIP 2.0 Website in 10 months, and more than 180,000 brochures ordered for distribution. The outreach strategy for 2016 and onward will be reevaluated and revamped to fill any gaps in enrollment efforts and ensure that no communities or subpopulations are being missed by outreach efforts.

During the first demonstration year, the State also increased efforts to educate existing providers about the presumptive eligibility system and to engage new providers, as specified in the STCs. Specifically, the State increased provider and member education around how to

<sup>22</sup> An example of a video advertisement that also exemplifies the With it/Without it them is available at: <https://www.youtube.com/watch?v=fkWd0eONRuc> as of April 8, 2016.

<sup>23</sup> <http://www.in.gov/fssa/hip/>

<sup>24</sup> Milliman. June 23, 2014. “1115 Waiver – Healthy Indiana Plan Expansion Proposal: Healthy Indiana Plan Budget Neutrality Projections.”

access and use the Hospital Presumptive Eligibility (HPE)/Presumptive Eligibility (PE) benefits and the requirements to transition from HPE/PE to full HIP coverage. Education efforts have increased, focusing on helping members understand how to change their health plan during the HPE/PE period and make payments.

The State also implemented the fast-track payment process in April, after the launch of HIP, with electronic payment option enhancements made in June. Fast Track allows an individual to make a \$10 payment prior to being determined eligible, which allows members to gain coverage more quickly. If a member opts to make this payment and is determined eligible, the effective date of coverage for them will be the first day of the month in which the fast track payment is made. If the individual is not eligible, the State will refund the payment. The ability to make a Fast Track payment via a paper invoice voucher began in March and health plans invoiced individuals who were potentially eligible days after they applied for HIP. In June of 2015, the State added a credit card payment option to the Fast Track process. An individual can make their Fast Track payment on-line via credit card at the point of filling out their on-line application. Those individuals that do not make the credit card payment are invoiced by their chosen health plan following the traditional billing process.

#### **E. Implementing the managed care opt-out solution for Native Americans/Alaskan Natives**

Individuals who are verified American Indian/Alaska Native are able to enroll in HIP without any cost sharing (including emergency room copayments) or POWER account contributions required on their behalf. They are eligible to receive HIP Plus services which include vision and dental coverage. All low-income parent/caretakers maintained their original benefits and those individuals who were found to be Medically Frail are eligible to receive HIP State Plan services. Verified American Indian/Alaska Native are also able to opt-out of the HIP, if they so choose, into a Fee for Service package that is similar to what individuals will receive in Traditional Medicaid.

To become a verified American Indian/Alaska Native, members must provide documentation to FSSA establishing this status, including:

- A document issued by a federally recognized tribe indicating tribal membership;
- An enrollment card for a federally recognized Indian Tribe;
- A certificate of degree of Indian blood issued by the Bureau of Indian Affairs;
- A tribal census document; or
- Any other documentation demonstrating eligibility for IHS services or under 42 CFR 447.50.

In year one, 88 Native Americans/Alaskan natives were enrolled in HIP Plus and 61 in the HIP State Plan. There were also 25 who opted out.

## F. HIP Program Protocols

Per the STCs, the State is responsible for developing program protocols and submitting them to CMS for approval. In year one, the State developed and submitted the following protocols to CMS for approval:

- HIP Link Program Protocol
- POWER Account Contributions and Copayments Infrastructure Operational Protocol
- POWER Account Contributions and Copayments Monitoring Protocol
- Emergency Room Co-pay Protocol

Each of these protocols were submitted on time according to the date specified in the Standard Terms and Conditions (STCs) agreed upon by both the State and CMS. The protocols have also all been approved by CMS.

## G. Evaluation

As part of HIP 2.0's STCs, CMS and Indiana agreed on a series of research questions and metrics to evaluate the efficacy of the program's goals. The State released a Request for Proposals on March 11, 2015 and selected an independent contractor, the Lewin Group, on June 1, 2015. When developing the program, Indiana set six goals (listed above) that aim to make healthcare more accessible and affordable for all Hoosiers and Lewin will evaluate these goals over the course of the demonstration.

Indiana drafted an evaluation plan, which details the State's plan for evaluating its original six goals. The evaluation plan includes detail on the data sources, the calculation methodology for the measures, and the analysis plan related to the identified measures. CMS approved the plan in December 2015. As part of the evaluation, Lewin developed four surveys. An initial iteration of the survey was completed in August 2015. The surveys include:

1. **Member survey:** respondents were both HIP Basic and Plus members, with a separate survey for each population
2. **Provider survey:** respondents were from a variety of practice types, including hospitals, Federally-Qualified Health Centers, Rural Health Clinics, solo/individual practices, single-specialty practices and multi-specialty practices
3. **Non-member survey:** respondents included members that applied and were approved for HIP but did not make their first POWER account payments and members that received presumptive eligibility for HIP but did not complete an application to fully enroll
4. **Previous member survey:** respondents included members who left the program for any reason (such as moving out of state) and members who's income was over 100 percent of the FPL and left the program for non-payment of their POWER account

Each of the surveys went through extensive review by CMS and was approved in December 2015. The findings from the initial survey were used for the evaluation of the Non-Emergency Transportation waiver. A more comprehensive look at the survey results will be included in the Interim Evaluation Report. In June of 2016, the Lewin Group will complete an Interim

Evaluation that quantifies the status of the State's six goals for HIP 2.0 and discusses the program's impact on Indiana residents.

The State also provided metrics on an ongoing-basis via the quarterly reports and policy-specific reports, including the Non-Emergency Transportation Evaluation, submitted in February 2016 (CMS provided an extension to the due date on this report due to delays in approving the evaluation design report) and the Provider Payment report (submitted December 30, 2015). The quarterly reports track enrollment from quarter to quarter, in addition to metrics associated with specific aspects of the HIP 2.0, such as HIP Link. Other reports include the Prior Claims Payment Report (submitted November 2015) and the Emergency Room Evaluation Design Report (submitted March 2016).

## Initial Program Metrics

During Year 1 of the HIP 2.0 Demonstration, FSSA has tracked the progress of HIP through a variety of different measures through the four Quarterly Reports submitted to CMS.

### A. Enrollment

**Table 1** shows HIP 2.0 enrollment as of January 31, 2016, the end of the first Demonstration Year. Enrollment figures are provided for HIP Basic and HIP Plus programs, by State and Regular categories,<sup>25</sup> and are stratified by FPL level. This stratification approach was employed to illustrate differences between the two benefit options, in addition to categorical differences amongst the populations.

**Table 1: Enrollment Progress at the End of the First Year of the Program**

Percent FPL	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Total HIP Enrollment in Income Level	State	Regular	Plus Total	Percentage of Total HIP Enrollment in Income Level	
<23%	52,969	25,417	78,386	41.95%	58,121	50,329	108,450	58.05%	<b>186,836</b>
23%-50%	2,631	6,866	9,497	34.53%	4,111	13,898	18,009	65.47%	<b>27,506</b>
51%-75%	2,596	10,063	12,659	33.79%	4,500	20,300	24,800	66.21%	<b>37,459</b>
76%-100%	2,216	10,556	12,772	31.29%	4,432	23,613	28,045	68.71%	<b>40,817</b>
Total <101%	60,412	52,902	113,314	38.72%	71,164	108,140	179,304	61.28%	<b>292,618</b>
101%-138%	1,771	3,454	5,225	12.75%	6,003	29,764	35,767	87.25%	<b>40,992</b>
>138%	1,329	943	2,272	25.63%	2,361	4,233	6,594	74.37%	<b>8,866</b>
<b>Grand Total</b>	<b>63,512</b>	<b>57,299</b>	<b>120,811</b>	<b>35.28%</b>	<b>79,528</b>	<b>142,137</b>	<b>221,665</b>	<b>64.72%</b>	<b>342,476</b>

Source: Enterprise Data Warehouse. Note that individuals over 138 percent of the FPL may continue on the program due to participation in the Transitional Medical Assistance (TMA) program or appeal status. Also, there is a small percentage of members in HIP Basic with incomes above 100 percent of the FPL. This occurs when HIP Basic members report an increase in income, at which time the State allows time to confirm the income increase. Once the income increase is confirmed, these members are moved to HIP Plus. This also occurs when TMA participants above 100 percent of the FPL fail to make a PAC; TMA participants are exempt from lock-out (regardless of income), therefore TMA participants above 100 percent of the FPL may be enrolled in Basic.

As of the end of the fourth quarter, approximately 370,000 Indiana residents are fully or conditionally enrolled in HIP. The number of fully enrolled members amounted to 342,476, consisting of 221,665 HIP Plus members and 120,811 HIP Basic members. However, it should be noted that total number HIP Plus members that were ever-enrolled in HIP 2.0 during the first demonstration year amounted to 281,395 Indiana residents – or almost 70 percent of the 407,631 members that were ever-enrolled for at least one month in HIP 2.0 from February 2015 through January 2016.

Some key observations from **Table 1** include:

<sup>25</sup> The State option provides a set of benefits for which only individuals in certain eligibility categories, including medically frail, low-income parents and caretaker relatives, transitional medical assistance participants, low-income 19- and 20-year-olds and pregnant women, are eligible.

- About two-thirds of members are fully-enrolled in Plus plans.
- 49,858 individuals or approximately 15 percent of enrollees in one of the HIP options had income over 100 percent of FPL.<sup>26</sup> This number may have been higher; many eligible Indiana residents were likely enrolled in a Marketplace plan during this time. As described above, the data available from the federal government on QHP enrollees are limited, which limits the ability for outreach. Members above 100 percent of the FPL are not required by the Marketplace to move to HIP and the Marketplace did not include any communications to enrollees explaining their new option if they were existing enrollees.
- Over 80 percent of Plus members (about 180,000 members) are below 100 percent of the FPL and are choosing to make contributions into their POWER account to avoid making copayments and to access enhanced benefits.

## B. Power Account Contributions from Third Parties

POWER accounts, designed after Health Savings Accounts, play a key role in the HIP 2.0 program. Designed to incentivize and empower individuals to manage their healthcare expenses, POWER accounts cover the \$2,500 deductible for all members (the health plan covers any costs exceeding \$2,500). In addition to required contributions from members, employers and non-profit organizations can help fund an individual’s POWER account contribution (PAC). The tables below present PACs made by either an employer or a non-profit organization.

**Table 2** provides information on the number of POWER accounts with employer contributions, and the amount of contributions.

**Table 2: Employer Power Account Contributions**  
(February 1, 2015 - January 31, 2016)

	YTD Total
Number of Employers Participating	124
Number of Members on Whose Behalf an Employer Makes a Contribution	131
Total Amount of Employer Contributions	\$5,563.69
Average Amount of Employer Contributions	\$42.47

Source: OMPP Quality and Reporting

As of the end of the fourth quarter, 124 employers contributed on behalf of a HIP member. Few members (131) have relied on assistance from employers for their POWER account contributions in the first year.

**Table 3** provides information on the number of POWER accounts with contributions from Non-profit Organizations, and the amount of contributions.

<sup>26</sup> Note that people with income above 100 percent of the FPL are not eligible for the Basic program, with the exception of Transitional Medical Assistance participants, hence there is a relatively small share of members above 100 percent of the FPL in Basic.

**Table 3: Non-Profit Organization Contributions**  
(February 1, 2015 - January 31, 2016)

	YTD Total
Number of Non-Profit Organizations Participating	75
Number of Members on Whose Behalf a Non-Profit Makes a Contribution	1,244
Total Amount of Non-Profit Contributions	\$17,482.29
Average Amount of Non-Profit Contributions	\$14.05

Source: OMPP Quality and Reporting.

As of the end of the fourth quarter, only 75 Non-profit Organizations contributed on behalf of 1,244 HIP Members. Combined with those receiving contributions from employers, less than one percent of the HIP 2.0 population that is required to make a contribution is relying on a non-profit organization or employer for assistance with their PAC.

### C. HIP 2.0 Closures

**Table 4** shows the total number of people that have left the program during the first year of the demonstration. Closure data are categorized by HIP category including Regular Plus, Regular Basic, State Basic, and State Plus. About 17 percent of these closures represent a change in Medicaid aid category, meaning they are being served in another Medicaid program.

**Table 4: HIP Closures: Program to Date**  
(February 1, 2015 - January 31, 2016)

HIP Category	Moved to Another Medicaid Category (Non HIP)	Moved Out of the Medicaid Program
Regular Plus	4,001	10,779
Regular Basic	3,226	16,009
State Basic	4,366	25,021
State Plus	1,509	13,160
Other	15	84
<b>Totals</b>	13,117	65,053
<b>Total HIP Closures</b>	<b>78,170</b>	

Source: Enterprise Data Warehouse

As of the end of the fourth quarter, there were 78,170 total closures.

**Table 5** presents the five most common reasons for closure. The most common reason for closure is that income exceeds program eligibility standards, with 12,358 closures and representing about 16 percent of all HIP closures. These members may be eligible for a tax-credit on the Marketplace.

**Table 5: Top 5 Reasons for All HIP Closures**  
(February 1, 2015 - January 31, 2016)

Reason for Closure	Number of Closures
Income exceeds program eligibility standards	12,358
Individual failed to comply with redetermination	12,319
Moved to another Medicaid category	12,689
Individual failed to provide required supporting documentation	10,334
Individual not an Indiana resident	5,549

Source: Enterprise Data Warehouse

**Table 6** presents the top five reasons for closure for the subset of the population with a household income under 100 percent of FPL.

**Table 6: Top Five Reasons for HIP Closures for Individuals with 100 percent FPL and Under**  
(February 1, 2015 - January 31, 2016)

Reason for Closure	Number of Closures
Individual failed to comply with redetermination	11,511
Moved to another Medicaid category	11,508
Individual failed to provide required supporting documentation	8,793
Income exceeds program eligibility standards	4,194
Individual not an Indiana resident	5,228

Source: Enterprise Data Warehouse

The most common reason for closure for individuals with 100 percent FPL and under is that they failed to comply with redetermination, with 11,511 closures. There were 11,508 members that were moved out of HIP 2.0 to another Medicaid program. In addition, there were 13,069 Plus members who were below 100 percent of the FPL and initially made a PAC, but then stopped. These members were shifted to the Basic program, and account for about seven percent of all members ever-enrolled in the Plus program with less than 100 percent of the FPL during the first demonstration year (180,022 members).

**Table 7** presents the top five reasons for closure for the subset of the population with a household income over 100 percent of the FPL.

**Table 7: Top Five Reasons for HIP Closure for Individuals Above 100 percent FPL**  
(February 1, 2015 - January 31, 2016)

Reason for Closure	Number of Closures
Income exceeds program eligibility standards	8,164
Failure to make POWER Account contribution	4,486
Failure to provide required supporting documentation	1,541
Individual failed to comply with redetermination	808
Individual acquired Medicare Part A or Part B	397

Source: Enterprise Data Warehouse

The most common reason for closure for individuals above 100 percent of the FPL is that their income exceeds program eligibility standards, with 8,164 closures. During the first demonstration year, there were also 4,486 members with income above 100 percent of the FPL that were closed out of the HIP program for failing to contribute to their POWER account. This amounts to 6.3 percent of all HIP members above 100 percent of the FPL who were ever-enrolled in Plus during the first demonstration year (70,660 members).

#### D. Emergency Room Utilization

Another key area of interest in monitoring the HIP program is Emergency Room utilization. **Table 8** documents the number of emergency room visits by HIP 2.0 enrollees through the first three quarters of the first demonstration year, broken out by HIP Plus, HIP Basic, and enrollees covered through the State Plan. Due to lags in claims processing, only the first three quarters of data are available to report.

**Table 8: Emergency Room Utilization**  
(February 1, 2015 - October 31, 2015)

Category	Number of ER visits adjudicated for the experience period	Number of ER visits deemed Emergent	Number of visits deemed non-emergent	Number of Adjudicated ER claims per 1,000 members	Percent of claims deemed emergent	Percent of claims deemed non-emergent
Plus	84,214	73,094	11,120	65	86.8%	13.2%
Basic	43,511	37,621	5,890	128	86.5%	13.5%
State Plan	136,440	117,468	18,972	90	86.1%	13.9%

Source: Office of Medicaid Policy and Planning Quality and Reporting

All groups of members have experienced a steady decrease in the percentage of claims deemed non-emergent over time. The percentage for Plus members has been relatively low compared to Basic and State Plan members throughout the first three quarters, but decreased from 14.2 percent in the first quarter to 12.7 percent in the third quarter. The decreases have been more substantial for Basic (30.1 percent to 12 percent) and State members (25.4 percent to 12.1 percent). These decreases may be indicative of the maturation of the program as members become increasingly accustomed to their new coverage benefits and incentives. In addition, this may also indicate that HIP Plus members making contributions utilize the system in different ways than HIP Basic members that are not making contribution.

#### E. Eligibility Processing

**Table 9** displays the application processing time, showing the average number of days between the date of application submission and eligibility determination. Data are broken out by Regular Plus, Regular Basic, State Plan Plus and State Plan Basic. Data is shown for the first demonstration year (February 2015 through January 2016).

**Table 9: Eligibility Processing**  
(February 1, 2015 - January 31, 2016)

Case Type	Average number of days from application to authorization	Average number of days from HIP Authorization for full eligibility	Number of pending HIP applications
Regular Plus	21.06	19.4	37,971
Regular Basic	23.58	33.5	2,095
State Plan Plus	20.35	23.4	6,145
State Plan Basic	30.71	15.4	16

Source: Indiana Client Eligibility System.

## F. HIP Link and Gateway to Work

During the initial year of the program, Indiana implemented two HIP initiatives designed to support HIP participants to find and maintain employment.

### *Gateway to Work*

Gateway to Work is a new feature of the Healthy Indiana Plan that helps connect members to Indiana’s workforce training programs, work search resources and potential employers. HIP members eligible for this program are those who work less than 20 hours a week, are not full-time students, or have not been referred to work training through SNAP. The Gateway to Work program is a no-cost voluntary program that offers HIP members a variety of services including an initial assessment of their skills and abilities to identify personal actions to achieve their employment goals.

Whether or not a HIP member chooses to participate or not will not affect HIP coverage or benefits. Once engaged in the Gateway to Work program, members may receive case management services, participate in a structured job readiness program and receive help with their job search. The program assists HIP members with completing job applications, creating resumes, improving job interview skills and job search assistance. Gateway to Work features tools to match participants’ experience and skills with employers who have job openings. Additional training, volunteer work experiences and/or education may be provided, as appropriate. In some cases, financial assistance is available to pay for short term skills training for high-demand jobs and/or classes to obtain the education and credentials needed to be competitive in today’s job market. Services may also be available to help members overcome barriers standing in the way of their success. These can include money for transportation or clothing required to start a new job.

As of January 31, 2016, a total of 307,156 letters have been mailed to inform HIP members of the Gateway to Work program. The Gateway to Work call center opened May 4, 2015; since opening, there have been 3,277 calls received from HIP 2.0 recipients with questions or an interest in participating. A total of 1,196 Gateway to Work orientations have been scheduled, with a total of 551 orientations attended.

## **HIP Link**

In June 2015, the HIP Link program implemented an employer portal to receive employer applications for participation. HIP Link allows HIP eligible members, their spouses, and HIP eligible dependents, to enroll in their employer's health plan and receive a HIP Link POWER Account valued at \$4,000 per person to help cover the costs of commercial insurance. Once an employee is enrolled in the employer-sponsored health plan, the employer will deduct the cost of premiums charged from the employee's pay, per normal procedures. In turn, the State will reimburse the employee directly for the amount of the deduction, minus the two percent required monthly contribution made by the employee, consistent with HIP Plus. The launch of the employer portal allowed the State to approve employers and employer health plans that offer HIP Link to their employees.

Within the first year of implementation, HIP Link enrolled 31 employers of various types and sizes. Due to the complexity of the program, the State initiated a slow roll-out with data users to beta-test the program and to ensure operations were running smoothly. This roll-out showed that the program works in diverse geographic regions and with employers of various sizes and types (e.g., private sector, public sector, schools, car dealerships, etc.). During this testing period, HIP Link staff were in frequent communication with both members and employees; daily one-on-one contact allowed for detailed feedback which led to program improvements. After incorporating changes after this test period, the program has an RFP to roll out the program on a broader basis.

Since its implementation, other HIP Link accomplishments include:

- Employer approval process extended to include onsite visits at the employer, which gives the option to discuss the program with eligible employees and facilitate enrollment.
- The program expanded essential health benefit options which increased employer enrollment.
- Employer plans already approved by the Indiana Department of Insurance as meeting the essential health benefits were posted online as having preapproved benefits for HIP Link.
- The HIP 2.0 call center has a separate line for HIP Link; all calls are tracked to identify areas for improvement. The call center will also be handling employer-related questions regarding the application process.
- Extensive resources have been developed for employers and employees including a detailed handbook and a video tutorial about the program to assist with all aspects of enrollment from the application process to reimbursement.
- Stakeholder engagement has involved outreach and presentations across the state. The focus is on empowering patient navigators and agents to become advocates for the program.
- Extensive outreach efforts to promote HIP Link will begin during 2016. The State will continue to augment resources to promote the program and bring on new expertise for marketing purposes.

The State has also continued efforts to develop the HIP Link program by submitting a State Plan Amendment, adding benefit standards for employer-sponsored insurance to qualify as HIP Link- eligible. These Alternative Benefit Plan (ABP) standards are only for HIP Link enrollees, therefore ensuring that employers participating in HIP Link are providing comprehensive benefits equal to a standard ABP. In the first year, there were three ABPs submitted and approved by CMS. Also in the first year, 31 employers enrolled in the program.

### G. Presumptive Eligibility (PE)

Hospitals, psychiatric hospitals, community mental health centers, federally qualified health centers, rural health centers and local county health departments are eligible to perform PE activities. Providers who elect to do so are considered “Qualified Providers” (QPs). The PE process utilizes a web-based application tool that allows the QP to enter information into the fields and then submit the application. The tool determines eligibility immediately and a determination letter is available for the QP and the member. This letter is the member’s proof of coverage for their PE eligibility. The letter can provide access to services during the time it takes for the eligibility to be visible to providers. Once an individual is assigned to a MCE, they are sent an invoice and are given the opportunity to participate in Fast Track that would apply to their full Indiana Health Coverage Programs (IHCP) application.

Individuals who are eligible for PE are given assistance in completing the full IHCP application so that they can access full benefits. This is done through education and training for QPs and with a state rule that holds QPs accountable for their performance. Before a provider can access the web based PE application tool, they must enroll with the State’s fiscal agent and complete the training and attestation. Training materials are available on the website utilized by Indiana Medicaid providers and the State’s standard communication process is utilized to provide program updates and reminders.

The PE program has been very active in Indiana, as described in **Table 10**. During the first nine months of the HIP 2.0 program, 107,366 applications for PE coverage were submitted. Out of those applications, 84,517 individuals had a PE benefit segment. Of those 84,517 PE members, 66,582 submitted an IHCP application for full coverage before their PE segment ended. Only 20,115 (31.48 percent) were approved for full coverage on any IHCP program.

**Table 10: Presumptive Eligibility Applications and Performance**  
(February 2015 - October 2015)

	PE Applications Submitted	PE Applications Approved	PE Applications Approved	IHCP Applications Submitted	Percent of PE members who submit an IHCP application	IHCP Applications Approved	Percent IHCP Applications Approved
<b>Total</b>	<b>107,366</b>	<b>84,517</b>	<b>78.72%</b>	<b>66,582</b>	<b>78.80%</b>	<b>20,115</b>	<b>31.48%</b>

Source: Enterprise Data Warehouse as reported in March 24, 2016 Presumptive Eligibility Standards Proposal.

Nearly 79 percent of PE applicants were approved for a PE segment. The simplicity of the application and the real time determination is one reason why so many people apply for PE. The top reasons for denial include: the applicant’s gross income exceeds program

requirements, applicant already has conditional HIP status, applicant already had PE segment in past 12 months, applicant is not an Indiana resident, and applicant does not meet citizenship requirements.

The percentage of PE individuals who submit a full IHCP application is 78.8 percent, but only 31 percent of them are actually found eligible for any Medicaid program. Determining the denial reasons for individuals who had PE and were then denied coverage based on their IHCP application required the State to research each case individually. In order to understand the reasons the PE members were denied, a sample of 19 individuals who had PE and were denied full coverage was analyzed. For the individuals researched, their denial reasons were in line with the denial reasons for all individuals filling out an IHCP application. That is, 14 were denied due to failure to provide verifications<sup>27</sup> and 5 were denied due to excess income. The most common reasons that a full IHCP applicant was found not eligible include: failure to cooperate in verifying income, income exceeds program eligibility standards, failure to verify Indiana residency, failure to provide required information and failure to cooperate in verifying assistance group composition.

**Table 11** reports the number of QPs completing HPE/PE applications for individuals (i.e., the number of providers and locations that are actually active in PE applications). The column “Total Potential Providers by Type” indicates the total number of specialty providers enrolled, for each type, in the Indiana Health Coverage Program.

**Table 11: Presumptive Eligibility Qualified Providers**  
(November 1, 2015 - January 31, 2016)

Provider Type	Number of Qualified Providers	Number of Qualified Provider Locations	Total Potential Providers by Type
Acute Care Hospital	107	109	168
Community Mental Health Center	19	40	25
Federally Qualified Health Center	23	63	68
Psychiatric Hospital	13	13	32
Rural Health Clinic	4	4	66
County Health Department	2	2	57
<b>Total</b>	<b>168</b>	<b>231</b>	<b>416</b>

Source: Indiana AIM

<sup>27</sup> Verification failures found include: income, Indiana residency, household composition, responses to all required questions on HIP application, and proof of application for children.

## Total Annual Expenditures

HIP 2.0 is cost-effective and continues to meet budget neutrality requirements. All Section 1115 Medicaid research and demonstration waivers are required to be budget neutral, meaning that the demonstration may not cost more to the federal government than it would have cost had it not been implemented. HIP 2.0 has met its federal budget neutrality targets for the first year of the demonstration. The estimated total cumulative cost for the first year of the demonstration (through December 31, 2015) was just over \$1.7 billion, including administrative costs. These costs are below the originally projected costs for this program.

## Detailed Annual Enrollment

In this section, additional detail is provided on how enrollment is distributed at the county level throughout the State, as well as by various member characteristics. In **Table 12**, total HIP 2.0 enrollment as of the end of the first demonstration year is displayed by race, age group and Aid Category. The HIP 2.0 program targets adults below the age of 65. The majority of members are below forty with 31 percent in their twenties and 28 percent in their thirties.

**Table 12: HIP 2.0 Enrollment by Member Characteristics at the end of the First Demonstration Year**

Member Cohort	Basic				Plus				Total HIP Enrollment
	State	Regular	Basic Total	Percentage of Total HIP Enrollment in Cohort Level	State	Regular	Plus Total	Percentage of Total HIP Enrollment in Cohort Level	
<b>Age Group</b>									
<20	2,680	2,526	5,206	49.63%	2,230	3,054	5,284	50.37%	10,490
20-29	28,375	22,325	50,700	47.81%	22,893	32,454	55,347	52.19%	106,047
30-39	22,076	16,078	38,154	39.63%	26,274	31,844	58,118	60.37%	96,272
40-49	8,168	9,580	17,748	27.39%	16,267	30,794	47,061	72.61%	64,809
50-59	2,404	6,147	8,551	16.82%	9,473	32,808	42,281	83.18%	50,832
60+	254	1,238	1,492	9.82%	2,518	11,187	13,705	90.18%	15,197
<b>Race</b>									
Asian	576	820	1,396	20.66%	1,351	4,011	5,362	79.34%	6,758
Black	17,638	16,233	33,871	50.54%	12,653	20,492	33,145	49.46%	67,016
Hispanic	3,408	2,815	6,223	37.81%	3,840	6,396	10,236	62.19%	16,459
Native American (opt-in)	0	0	0	0.00%	55	69	124	100.00%	124
White	41,703	37,084	78,787	31.84%	60,776	107,886	168,66	68.16%	247,449
Other	632	942	1,574	26.95%	980	3,287	4,267	73.05%	5,841
<b>Grand Total</b>	<b>63,957</b>	<b>57,894</b>	<b>121,851</b>	<b>35.46%</b>	<b>79,655</b>	<b>142,141</b>	<b>221,79</b>	<b>64.54%</b>	<b>343,647</b>

Source: Enterprise Data Warehouse. Note that these estimates were generated at a later date (April 22, 2013) than those for the Quarterly Report (which are displayed in Table 1). Due to constantly changing enrollment status of HIP members, there are slight differences (less than 1 percent) in the total enrollment estimates presented in this table (and used for the maps) than those presented in Table 1 and discussed previously.

Statewide, roughly three-quarters of the Indiana population with an income under 138 percent of the FPL is white.<sup>28</sup> The membership in HIP 2.0 reflects this as the vast majority of members in the State are white – about 72 percent. Blacks account for about 20 percent of the HIP 2.0 population, representing most of the non-white membership.

**Table 13** display HIP 2.0 enrollment at the county level. Enrollment spans throughout all counties in Indiana, from rural and sparsely populated areas such as Benton County and Martin County to more densely populated urban areas such as Marion County.

<sup>28</sup> 2015 Annual Social and Economic Supplement (ASEC) of the Current Population Survey (CPS).

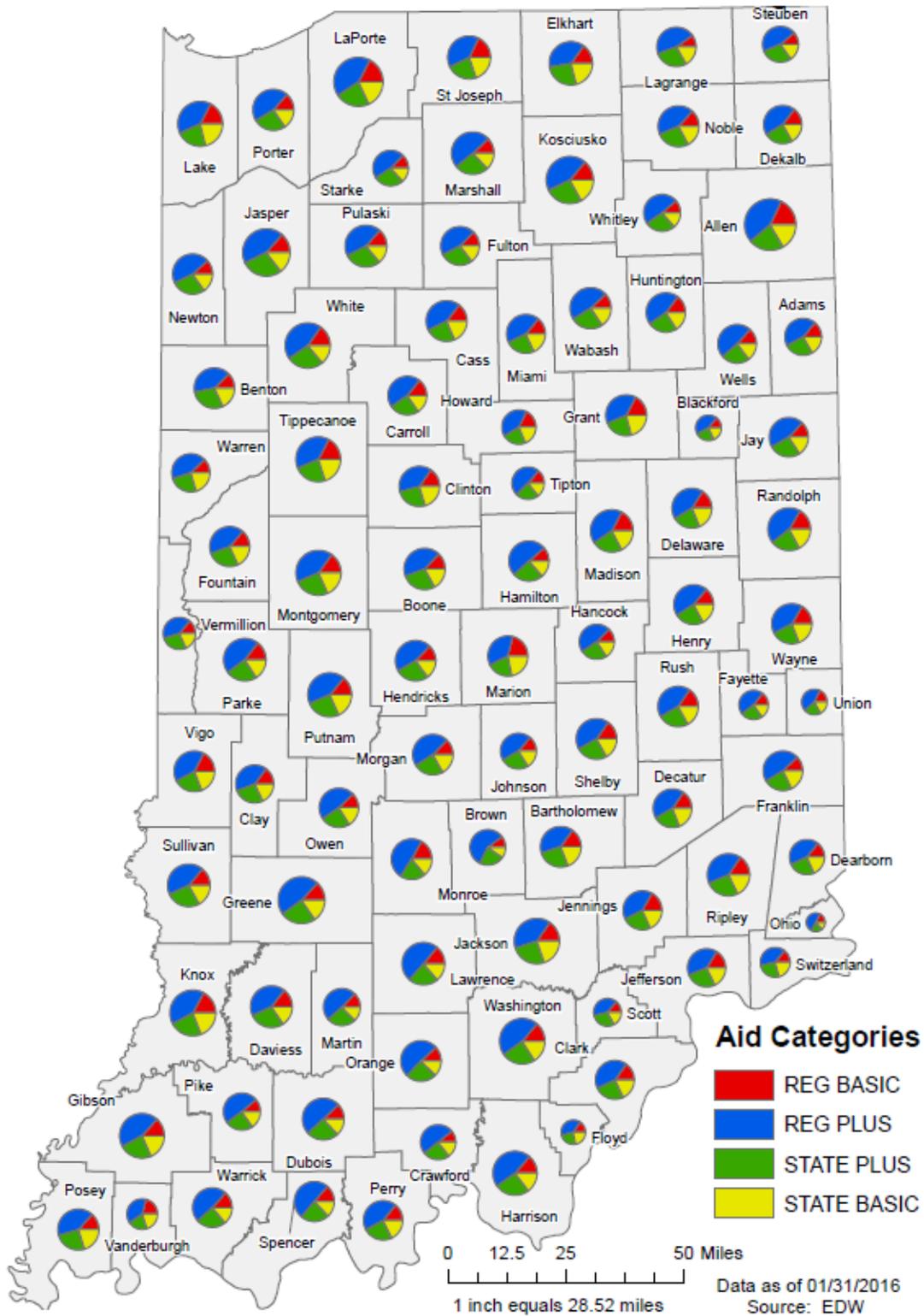
The maps in **Exhibit 1**, **Exhibit 2** and **Exhibit 3** display how the HIP 2.0 membership is distributed across Aid Category, age group and race for each county. In **Exhibit 1**, the distribution of HIP 2.0 members by Plus, Basic, State and Regular Aid Category are displayed. For each county, there are more Plus members than Basic members. **Exhibit 2** displays the distribution of HIP 2.0 members by age group across all counties in Indiana. In general, the distribution of enrollment by age for each county is similar to that at the State level. **Exhibit 3** displays the distribution of HIP 2.0 members by race across all counties. There are certain counties with larger shares of minority populations. These include the more densely populated urban areas, such as in the upper west part of the state near Gary, in the middle of the state near Indianapolis, and near South Bend and Fort Wayne, toward the north central and north east part of the state.

**Table 13: HIP 2.0 Enrollment by County as of the end of the First Demonstration Year**

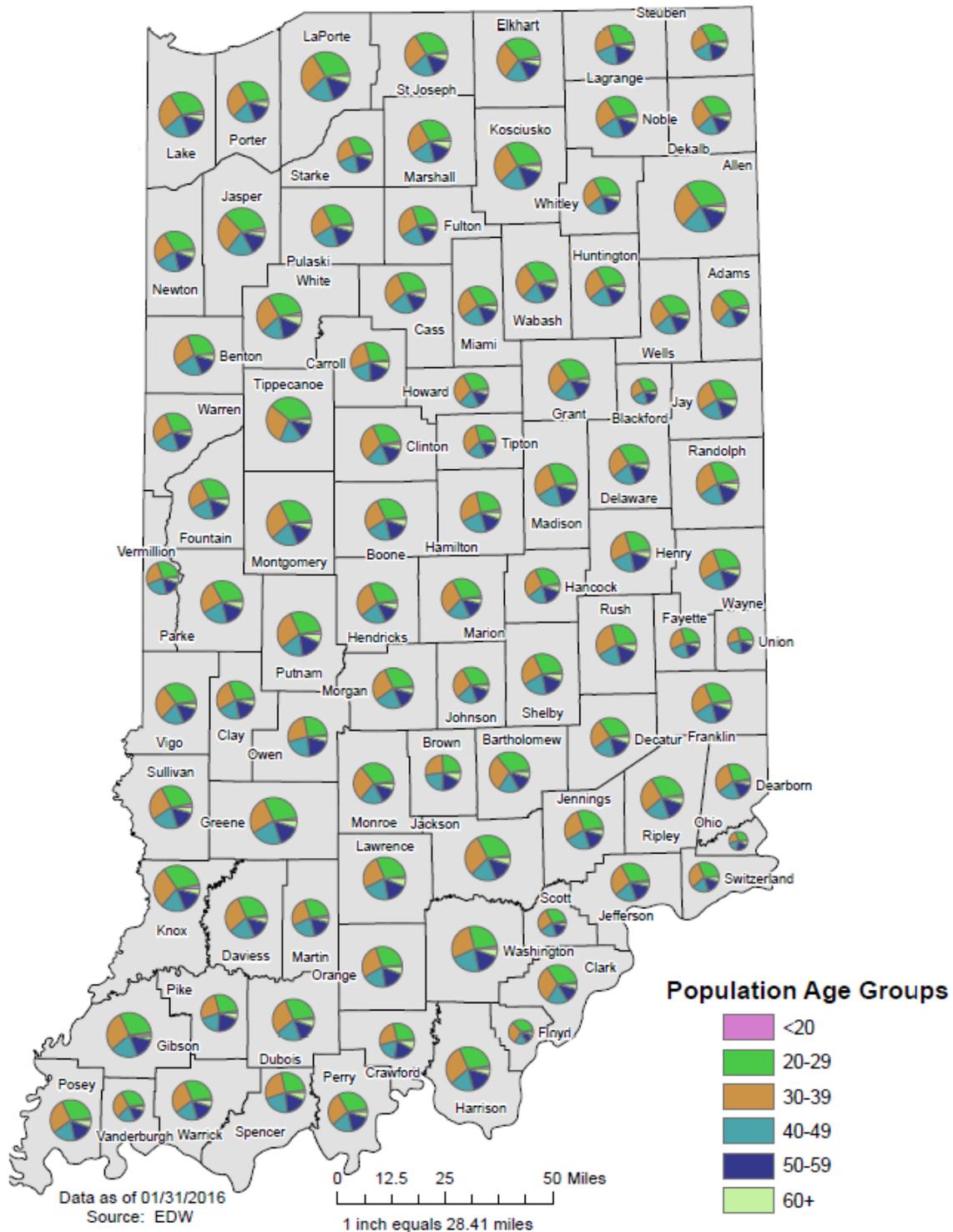
County Name	Total HIP Enrollment	County Name	Total HIP Enrollment	County Name	Total HIP Enrollment
Adams	1,102	Hendricks	3,737	Pike	650
Allen	19,110	Henry	3,301	Porter	6,969
Bartholomew	2,782	Howard	5,576	Posey	944
Benton	460	Huntington	1,668	Pulaski	771
Blackford	857	Jackson	1,827	Putnam	1,653
Boone	1,709	Jasper	1,507	Randolph	1,638
Brown	775	Jay	1,111	Ripley	1,225
Carroll	804	Jefferson	1,766	Rush	926
Cass	1,849	Jennings	1,732	Saint Joseph	14,244
Clark	4,667	Johnson	5,820	Scott	1,817
Clay	1,724	Knox	2,319	Shelby	2,396
Clinton	1,664	Kosciusko	2,995	Spencer	794
Crawford	703	Lagrange	836	Starke	1,852
Daviess	1,478	Lake	32,571	Steuben	1,358
Dearborn	2,050	Laporte	7,389	Sullivan	1,450
Decatur	1,197	Lawrence	2,877	Switzerland	583
Dekalb	1,589	Madison	9,411	Tippecanoe	6,359
Delaware	7,769	Marion	66,964	Tipton	625
Dubois	931	Marshall	1,875	Union	395
Elkhart	7,897	Martin	561	Vanderburgh	10,012
Fayette	2,168	Miami	2,255	Vermillion	1,140
Floyd	3,159	Monroe	6,599	Vigo	7,613
Fountain	914	Montgomery	1,641	Wabash	1,439
Franklin	1,116	Morgan	3,884	Warren	349
Fulton	1,127	Newton	784	Warrick	1,835
Gibson	1,393	Noble	1,888	Washington	1,826
Grant	4,677	Ohio	203	Wayne	4,363
Greene	2,064	Orange	1,362	Wells	985
Hamilton	5,564	Owen	1,453	White	1,056
Hancock	2,564	Parke	1,013	Whitley	1,068
Harrison	1,697	Perry	827	<b>Total</b>	<b>343,647</b>

Source: Enterprise Data Warehouse. Note that these estimates were generated at a later date (April 22, 2013) than those for the Quarterly Report (which are displayed in Table 1). Due to constantly changing enrollment status of HIP members, there are slight differences (less than 1 percent) in the total enrollment estimates presented in this table (and used for the maps) than those presented in Table 1 and discussed previously.

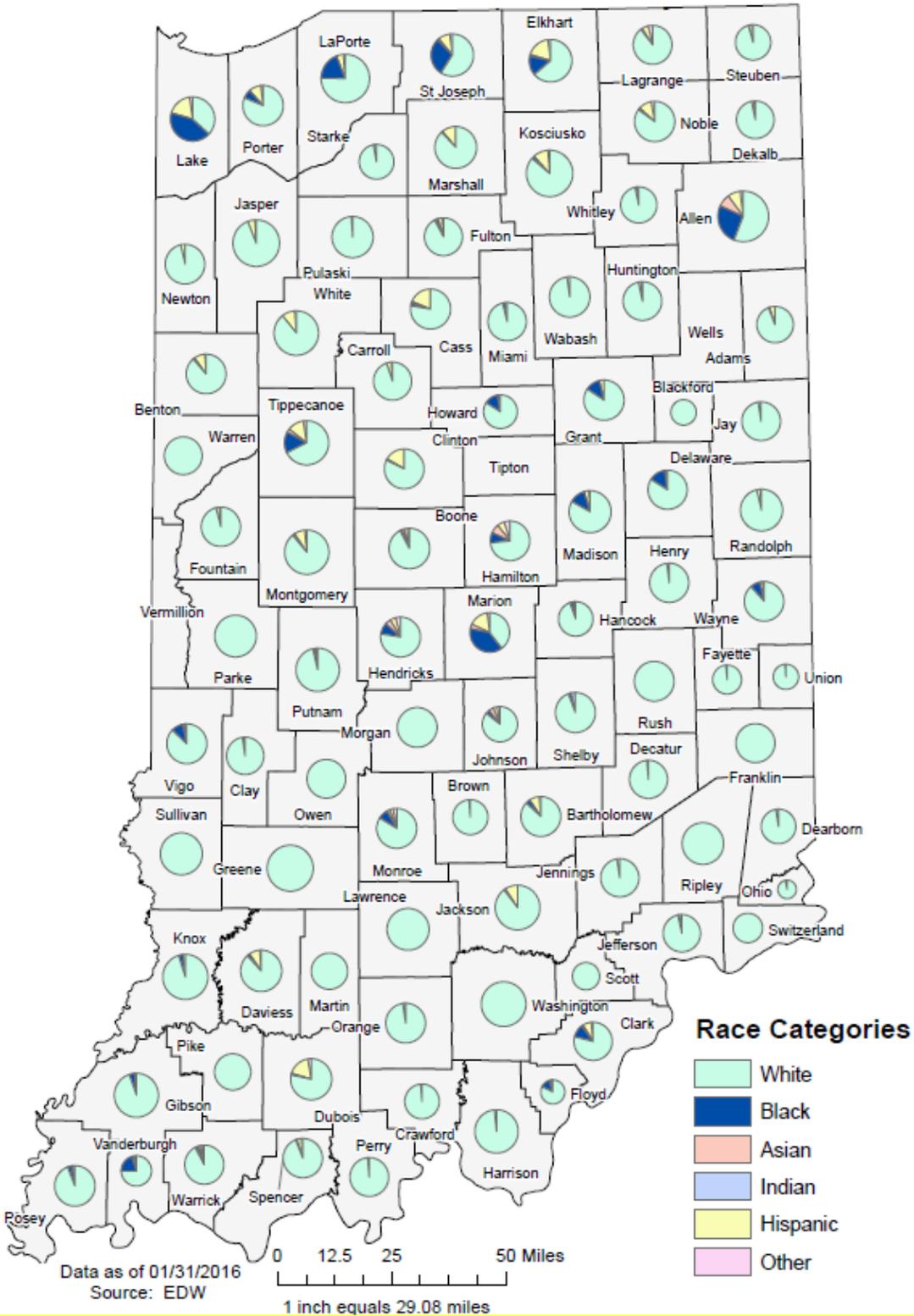
Exhibit 1: HIP 2.0 Enrollment by County and Aid Category as of the end of the First Demonstration Year



**Exhibit 2: HIP 2.0 Enrollment by County and Age Group as of the end of the First Demonstration Year**



**Exhibit 3: HIP 2.0 Enrollment by County and Race as of the end of the First Demonstration Year**



## Comprehensive State Quality Strategy

Per the STCs, Indiana has updated its Medicaid managed care quality strategy to incorporate the HIP 2.0 demonstration. This quality strategy sets forth nine metrics for the HIP 2.0 program. The External Quality Review Organization will be calculating these metrics, and assessing them against the goals established in the quality strategy, as part of its 2015 annual external quality review. This report is expected to be available in mid-2016 and the HIP initiatives will be reported at that time.

## Conclusion

By the end of the first year of the program, HIP 2.0 has seen accomplishments in an array of areas, including enrollment – reaching approximately 370,000 low-income Indiana residents fully or conditionally enrolled. The Plus program makes enhanced benefits (e.g., vision and dental coverage) available to HIP 2.0 members, while empowering them to take more control of their health care. Even members who are below 100 percent of the FPL, who have options for Basic coverage, are largely choosing to make their PAC payments in order to maintain their enhanced benefits. Also, the vast majority of members surveyed indicated that they are satisfied or very satisfied with the program and would re-enroll even if they had to pay more to be in the program.

HIP 2.0 is well into Year 2 of the waiver and the program staff continues to expand on the goals of the program to:

- Continue to outreach to enrollees and providers to improve understanding of the program and consumer directed health care.
- Refine and expand the outreach strategy to emphasize enrollment among key demographics (e.g., rural communities)
- Continue to educate key stakeholders and assist with enrollment efforts
- Encourage appropriate use of emergency departments and redirection of care to primary care physicians and urgent care through co-pays, as well as maintenance of overall health and preventative care
- Work to decrease the number of uninsured unemployed Indiana residents through increasing the number of employers participating in HIP Link

The next major report required for the HIP program will be the Interim Evaluation Report, to be submitted to CMS in June 2016. This report will review the Goals set forth in the 1115 Waiver and evaluate them using a series of metrics calculated with enrollment, claims, and survey data.